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Letter dated 9 June 2009 from the Permanent Representative of Jamaica to the United Nations addressed to the President of the Economic and Social Council

Attached herewith is the national report of Jamaica on progress towards the achievement of the internationally agreed goals, including the Millennium Development Goals, for the annual ministerial review to be held during the high-level segment of the 2009 substantive session of the Economic and Social Council (see annex).

I should be grateful if you would circulate the present letter and its annex as a document of the Council, under item 2 (b) of the provisional agenda.

(*Signed*) Raymond O. **Wolfe**
Ambassador
Permanent Representative

* E/2009/100.

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Annex to the letter dated 9 June 2009 from the Permanent Representative of Jamaica to the United Nations addressed to the President of the Economic and Social Council

National report of Jamaica on the Millennium Development Goals for the annual ministerial review of the Economic and Social Council

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List of abbreviations and acronyms

AIDS	: Acquired immunodeficiency syndrome
BCG	: Bacillus Calmette-Guérin
CAREC	: Caribbean Epidemiology Centre
CARICOM	: Caribbean Community
CDERA	: Caribbean Disaster Emergency Response Agency
CO_2	: Carbon dioxide
COSHOD	: Council for Human and Social Development
DPT	: Diphtheria
ECOSOC	: Economic and Social Council
EMS	: Environment management systems
EPI	: Environmental Performance Index
ESSJ	: Economic and Social Survey of Jamaica
FCF	: Forestry Conservation Fund
GDP	: Gross domestic product
GSAT	: Grade Six Achievement Test
HEART	: Human Employment and Resource Training
HIV	: Human immunodeficiency virus
ICT	: Information and communication technologies
IADB	: Inter-American Development Bank
JSIF	: Jamaica Social Investment Fund
LAMP	: Land Administration and Management Programme
MDG	: Millennium Development Goals
MOH	: Ministry of Health
NCDs	: Non-communicable lifestyle diseases
NGO	: Non-governmental organization
NHF	: National Health Fund

NIS	: National insurance scheme
NTA	: National Training Agency
ODA	: Official development assistance
OECD	: Organization for Economic Cooperation and Development
OPV	: Oral polio vaccine
PAHO	: Pan American Health Organization
PATH	: Programme of Advancement Through Health and Education
PIOJ	: Planning Institute of Jamaica
PHC	: Primary health care
SEA	: Strategic environmental assessment
SID	: Small island developing State
STIs	: Sexually Transmitted Infections
TB	: Tuberculosis
TV	: Television
UN	: United Nations
UNESCO	: United Nations Educational, Scientific and Cultural Organization
UNFPA	: United Nations Population Fund
UNICEF	: United Nations Children's Fund
UNIFEM	: United Nations Development Fund for Woman
USA	: United States of America
VEN	: Vital, essential and necessary
VPA	: Violence Prevention Alliance
WHO	: World Health Organization

Executive summary

Jamaica has a population of almost 2.7 million and is a Caribbean small island developing state, ranked third among 75 countries as a natural disaster hotspot (World Bank 2005). It is a heavily indebted country. At 111.3% (2007) it has the fourth largest debt-to-GDP ratio in the world, with debt servicing consuming 56.5% of the 2009/10 budget. Remittances, tourism, and bauxite account for over 85% of foreign exchange. Coupled with reliance on imports, particularly oil, food and consumer goods, this makes the economy acutely vulnerable to exogenous shocks, as evidenced by the initial impact of the global economic crisis. Inflation is up, remittances are down, tourism is stable but heavily discounted, and returns from bauxite are predicted to be only 30% of last year's (2008) figures. Major bauxite plants are closed for at least a year, there are 1,850 job losses and 850 staff are on a three-day week. According to Labour Force Reports, there were 14,750 job losses in other sectors from October 2008 to May 2009. This is in the context of a decline in ODA due to Jamaica's middle income categorization.

The country has made good progress in eight out of the 14 MDG targets for 2015. Jamaica has already achieved the targeted reduction in absolute poverty, malnutrition, hunger and universal primary enrolment and is on track for combating HIV/AIDS, halting and reversing the incidence of malaria and tuberculosis, access to reproductive health, and provision of safe drinking water and basic sanitation. Lagging in gender equality and environmental sustainability, it is far behind in child and maternal mortality targets. Of great concern is the significant slippage in the proportion of the urban population living in unacceptable living conditions or slums.

Jamaica's overall health status is good. It has a good health record in primary health care, and can share several best practices. It needs financing at affordable, concessionary rates to stimulate renewal of the primary care model and other support, including partnerships with educational institutions to build capacity and expand the training of health personnel. Many migrate to developed countries leaving Jamaica with chronic staff shortages in some areas.

Homicidal violence, 77% by the gun, is a leading social problem; it is male on male, youth on youth, poor on poor.[1] Of the youth, aged 15-24, 26.2% males and 7.9% females are illiterate. Unattached youth, those who are not in school, unemployed and not participating in any training course, comprise roughly 30% of the total youth population. About a quarter of unattached youths had attained only a grade 9 level or less of education.[2] This makes female youth vulnerable to sexual exploitation and adolescent pregnancy and puts male youth in an extremely vulnerable position, which might lead to participation in criminal gangs.

[1] *Economic and Social Survey Jamaica, 2008* (Kingston: Planning Institute of Jamaica, 2009).

[2] Jamaica Adult Literacy Survey, 1999.

Unemployment has declined from 15% in 1990 to 10.6% in 2008. This decrease is partly due to the growth of the informal sector from an estimated 28% of GDP in 1989 to an estimated 43% in 2001, probably one of the several contributors to a significant reduction in poverty levels.[3]

Unless there are mitigating actions, global recession will negatively impact the achievements in poverty reduction, since these have been based on controlled inflation, growth of the informal sector to over 40% of the economy, and growth in remittances. Violence and the numbers of vulnerable youth are likely to increase and together these factors will cause slippage in MDG progress. Under global partnership developed countries need to continue and, where possible, increase support to the development process through aid, debt forgiveness, debt equity swaps, technology transfer, support for regional and global partnerships, joint ventures and structured arrangements between donor and recipient countries to ensure benefits from migration.

[3] Ibid., selected years; also, *The Informal Sector in Jamaica* (Inter-American Development Bank (IADB), 2002).

Overview

Jamaica is a middle income small island developing state (SID) in the Caribbean region, ranked by the United Nations in the medium human development category. Its population is near 2.7 million with a GDP per capita of US$4,816.7 at the end of 2007. Annual population growth is 0.4% and life expectancy 74.1 years. The country has a long tradition of stable two-party democracy. A recently reformed electoral system ensures elections free of corruption through, among other things, electronic voting.

Endowed with natural assets, Jamaica has arable land, outstanding scenic beauty, high levels of biodiversity, white sand beaches and modest mineral resources. These provided for much of the early income growth generated from a vibrant tourist industry, sugar, bananas and significant bauxite mining. Today the sugar and banana industries are in decline, partly due to the ending of trade preferences. Jamaica's tourist industry has strengthened and is of a high standard, attracting 2.9 million visitors a year. Its bauxite industry has, until recently, been expanding. Overall, unemployment has declined from 15% in 1990 to 10.6% in 2008. This decrease is partly due to the growth of the informal sector from an estimated 28% of GDP in 1989 to an estimated 43% in 2001,[4] probably one of the several contributors to a significant reduction in poverty levels.

For the past 40 years, however, there have been prolonged periods of low economic growth, large fiscal deficits, and weak export performance. Real gross domestic product grew by only 0.8% per annum from 1973 to 2007, although in the last decade it has been 1.3%.[5] Remittances from the Jamaican Diaspora have been escalating, and are now the country's leading source of foreign exchange totaling over US$2B in 2008. The country is heavily indebted and with a debt-to-GDP ratio of 111.3% (2007) has the fourth highest ratio in the world. In the latest 2009/10 budget, debt servicing (56.5%) and wages and salaries for civil servants (22.5%) left very limited fiscal space for development priorities such as infrastructure and social programmes. Education received 12.6%, national security 8.2% and health 5.3%. It is important to note that the debt includes the sum absorbed by the Jamaican government in the wake of the financial sector crisis of 1995-96, amounting to 44% of GDP. Most of the resultant debt is held by local creditors, and was 53.7% of total debt in January 2009. Since the crisis, more stringent monitoring and regulation of the financial sector has been introduced.

The global recession is now having a significant impact on the economy. Falling demand for alumina on the world market has resulted in the closure of major bauxite operations for at least one year, resulting in 1,850 job losses, another 850 jobs taking a 40% salary cut from a shorter work week, and a predicted 70% decline in bauxite revenues for the next financial year. There were 14,750 job losses from other sectors

[4] *The Informal Sector in Jamaica.*

[5] Vision 2030 Jamaica - National Development Plan.

between October 2008 and May 2009.[6] From November 2008 to February 2009, remittances, which have been increasing every year for a decade, were down by 21%. Up to the end of February 2009 tourist arrivals had continued to increase but earnings were down due to heavy discounting. Arrivals and average expenditure per visitor are expected to decline in the future. Inflation is increasing: the Jamaican dollar devalued against the US$ by 22% from September 2008 to mid-February 2009. The social impact of the crisis has not yet been documented, but already property crimes are reported by the police to be increasing markedly island wide.[7]

Remittances, tourism, and bauxite together account for over 85% of Jamaica's foreign exchange. Coupled with a reliance on imports particularly oil, food and consumer goods, this makes the Jamaican economy acutely vulnerable to exogenous shocks as evidenced by the initial impact of the global economic crisis. Unless mitigated, these impacts will negatively affect MDG progress.

A great internal challenge facing Jamaica is homicidal violence with a murder rate at 60 per 100,000 persons in 2008. In this respect Jamaica is also part of a broader landscape: the highest interpersonal violence mortality rates worldwide are found in the Americas among males 15 to 29 years of age.[8] Despite its high murder rate Jamaica has remained an outstanding tourist destination because this violence has rarely been directed at non-Jamaicans. Its characteristics are male on male, poor on poor, and youth on youth. Half of those admitted to high security adult correctional centres for major crimes in 2007 were males between 17 and 30 years of age. The ratio of males to females who commit major crimes is 49:1.

Seventy-seven percent of murders in 2008 were committed using guns. Jamaica has become a trans-shipment point between the USA and South America and this gun trade has increased their availability, facilitated by drug profits. The cost of crime and violence is undoubtedly a factor in Jamaica's stagnant growth. A World Bank Study conducted in 2002, found the cost of crime and violence in 2001 to be 3.7% of GDP.[9]

Jamaica is highly vulnerable to hurricanes, flooding, and earthquakes. In a 2005 World Bank ranking of natural disaster hotspots Jamaica ranked third among 75 countries with two or more hazards, with 95% of its total area at risk.[10] Between 2004 and 2008, five major events caused damage and losses estimated at US$1.2B. These have had significant impact on human welfare, economic activities, infrastructure, property

[6] Accumulative Redundancies Reported by Quarter, Ministry of Labour and Social Security.

[7] ESSJ, 2008.

[8] (World Health Organization, 2002) *Injury Chart Book* p. 61.

[9] http://info.worldbank.oreetools/docs/library/49114/jm_crime.pdf.

[10] World Bank, *Natural Disaster Hotspots: A Global Risk Analysis*. Disaster Risk Management Series #5 (World Bank, 2005).

losses and natural resources. Outbreaks of dengue and leptospirosis experienced in 2007 were largely influenced by weather conditions.

Vision 2030 Jamaica - National Development Plan

The Government of Jamaica, in collaboration with the private sector and civil society, has prepared a long term National Development Plan: Vision 2030 Jamaica. The Plan envisages Jamaica reaching developed country status by 2030. It introduces a new paradigm, redefining the strategic direction. The old paradigm for generating prosperity was focused on exploiting the lower forms of capital — sun, sea and sand tourism — and exporting sub-soil assets and basic agricultural commodities. These "basic factors" cannot create the levels of prosperity required for sustained economic and social development. The new route is the development of the country's higher forms of capital — the cultural, human, knowledge and institutional capital stocks — coupled with the reduction of inequality, which will move the society to higher stages of development.

MDG progress matrix for Jamaica

Goal Targets	Progress Dec 2007	Explanation	Comment
1. Eradicate Poverty & Hunger			Causal factors include reduction in inflation, growth of informal sector, increase in real wages, and probably include remittances. Vulnerable to exogenous shocks. **Likely to be unsustainable under global recession.**
1a. Halve, between 1990 & 2015, the proportion of people below the poverty line	**Achieved** (Table 1)	Reduced by two-thirds.	
1b. Halve, between 1990 & 2015, the proportion of people who suffer from hunger	**Achieved** (Table 1)	Proportion of under weight children <5 yrs reduced by Three-quarters. Proportion of food poor reduced by two-thirds.	
2. Achieve Universal Primary Education			Problem not access but quality of education, under-performance of boys, & attendance problems connected with poverty.
2a. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	**Achieved** (Table 2)	Net enrolment over 90%. Gross enrolment almost 100%	
3. Promote Gender Equality and Empower Women		No gender disparity at primary level. Gender disparity begins at grade 6 in the primary completion rate and peaks at grade 9 of secondary levels as boys drop out. Males under-represented at tertiary level by 2:1. Low representation of women in Parliament **(13%)**	Problems include under-performance of boys, unemployment rate among women (over twice that of men), and cultural barriers affecting female participation in governance.
3a. Eliminate gender disparity in primary & secondary education, preferably by 2005, & to all levels of education no later than 2015	**Lagging** (Table 3)		

Goal Targets	Progress Dec 2007	Explanation	Comment
4. Reduce Child Mortality 4a. Reduce by two-thirds, between 1990 & 2015, the under-five mortality rate	**Far behind** (Table 4)	Under-five mortality rate only reduced by 14% up to 2005. Infant mortality rate reduced by almost one-third.	Immunization rates high. At Jamaica's comparatively low mortality levels major resources needed to reach target. 70% of infant deaths occur in perinatal period. There are unresolved data management problems in this area.
5. Improve maternal health 5a. Reduce by three-quarters, between 1990 & 2015, the maternal mortality rate 5b. Achieve by 2015, universal access to reproductive health	**Far behind** (Table 5) **On track** (Table 5)	Unresolved data management problems also exist in this area. Data available indicate a 20% reduction over 14 yrs Close to universal access to ante-natal care. Only 10% unmet need for family planning.	Deaths from direct causes halved over 10 yrs, but 83% increase in deaths from indirect causes e.g., HIV/AIDS, NCDs, unsafe abortions. 47% shortage in midwife cadre, lost to migration. Reproductive issue among young girls is forced sex.
6. Combat HIV/AIDS, Malaria and Other Diseases 6a. Have halted by 2015 & begun to reverse the spread of HIV/AIDS 6b. Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it 6c. Have halted by 2015 & begun to reverse the incidence of malaria and other major diseases	**On track** (Table 6) **On track** (Table 6) **On track** (Table 6)	1st decline in AIDS deaths in 2005 and in AIDS cases in 2006. Access to retroviral drugs jumped from <5% in 2000 to 60% in 2008. Local malaria outbreaks since 2006 swiftly contained, no deaths. TB incidence/deaths	Major reason for decline was access to antiretroviral treatment through Global Fund. Malaria had been eliminated for many years but there were 186 imported cases in 2006, followed by local transmission in 2007. Poor sanitation in urban inner-city areas now cited for more recent local outbreaks in Kingston.

Goal Targets	Progress Dec 2007	Explanation	Comment
7. Ensure Environmental Sustainability 7a. Integrate principles of sustainable development into country policies & programmes & reverse the losses of environmental resources 7b. Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss 7d. Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation (Table 7) 7d. By 2020 have achieved a significant improvement in the lives of at least 100 million slum dwellers	**Lagging** **Lagging** (Table 7) **On track** (Table 7) **Slipping back** (Table 7)	Policy coherence & long-term sustainable development planning has been lacking. Achieved elimination of ozone depleting substances; inadequate progress in protected areas; slippage in reduction of CO2 emissions. 92% have access to safe drinking water, while 98.9% have access to basic sanitation. UN data suggests slippage. Insufficient data collected nationally.	National Development Plan is important step towards policy coherence/ long-term integrated sustainable development. Reliance on, high use, and inefficient production of oil-based energy a major problem. Identified as a priority policy focus. Environmental data collection mechanisms a challenge. Access to water has improved but challenge is sanitation issues e.g., management of solid waste and poor hygiene. Urban population has grown from 35% in 1991 to current 52%. Poor infrastructure a major problem. 1 000 units recently completed in public inner-city housing programme with social interventions. Social Investment Fund has new inner-city infrastructure projects.

Jamaica is making good progress in eight out of the 14 targets for 2015. The achievements are in reduction of absolute poverty, reduction of malnutrition and hunger, and achievement of universal primary education. While not devaluing these achievements, the analysis that follows indicates that for poverty the achievement may be fragile and for education Jamaica has a problem with quality.

In those targets where Jamaica is on track — combating HIV/AIDS, halting and reversing the incidence of diseases such as malaria and tuberculosis, access to reproductive health, and provision of safe drinking water and basic sanitation — gains are more solid, despite remaining challenges.

The areas in which Jamaica lags—gender equality and environmental sustainability — reveal some interesting and important lessons. For gender they include male under-performance in education and the enigma of a higher rate of unemployment for women, despite their educational gains. To get on track with environmental sustainability will require dealing with inefficient energy production and oil dependency, improving

protection of biodiversity and habitat, especially coastal areas and, critically, achieving policy coherence so that sector policies are not working at cross purposes.

Where Jamaica is far behind, in targets for child and maternal mortality, it is recognized that this is partly because Jamaica already has comparatively low mortality rates and further gains are mainly dependent on increased financial, technological and human resources.

The greatest concern is around the area of slippage: the proportion of the urban population living in unacceptable living conditions or slums. It is noted that monitoring is inadequate as the annual national household survey does not measure this, relying instead on United Nations agencies for information on slippage. The implications in this area can negatively impact all the MDGs.

The Millennium Development Goal areas[11]

Poverty and hunger (MDG 1)

TABLE 1 - GOAL 1: Eradicate Poverty and Hunger				
Targets	**Indicators *(source)***	**1990**	**2000**	**2007**
1a.	1.1 Proportion of population living below the national poverty line	28.4%	18.7%	9.9%
	1.4 Status of poorest (and wealthiest) quintiles in national consumption	6% (46%)	6.7% (46.1%)	6.8% (45%)
	(Jamaica Survey of Living Conditions)			
1b.	1.9 Prevalence of underweight children under 5 yrs of age	8.4%	5.1%	2.2%
	1.10 Proportion of population below minimum level of dietary energy consumption (the food poor)	8.3%	4.9%	2.9%
	(Jamaica Survey of Living Conditions)			

Despite minimal economic growth (Table 1), Jamaica has experienced a rapid decline in poverty as measured by a consumption indicator. A key question is how much these data represent a substantial movement out of poverty and how much is merely a movement of the transient poor just above the poverty line?[12] Certainly, real mean per capita consumption has increased since 1990.

A number of factors are thought to have led to the poverty rate reduction, such as, government fiscal policy which has prioritized and successfully reduced inflation and

[11] Data on targets and indicators for all MDG areas are based on availability and national relevance.

[12] One credible estimate based on the annual household *Jamaica Survey of Living Conditions* is that one-third of households move in and out of poverty repeatedly (Handa. S. 2008) *Moving on up?* "The dynamics of poverty in Jamaica". Powerpoint presentation to 2008 Planning Institute of Jamaica, Jamaica Survey of Living Condition Conference).

the growth of the informal sector. The phenomenal growth in remittances is also likely to have reduced poverty.[13] Indicators of under nutrition reveal good progress for children and the general population, but obesity is an emerging problem. Despite the achievement of the poverty target, the level of inequality has not moved. Moreover, because poor households often include many children they are unequally impacted by poverty, with 22% of children living below the poverty line.[14]

In 1996, the Government instituted a National Poverty Eradication Policy and Programme. This encompassed *inter alia* rural electrification, micro-finance, and a Social Investment Fund that has greatly assisted early childhood institutions, social services, water and sanitation projects, rural feeder roads, inner-city infrastructure as well as community organizational capacity building.

In order to improve the coherence, efficiency and targeting of social assistance, in 2002, Government introduced a Social Safety Net Reform Programme and established a conditional cash transfer Programme of Advancement Through Health and Education (PATH), rationalizing and merging the income transfer components of three former programmes, significantly reducing leakage. Children are the main beneficiaries but PATH also covers the elderly poor, other destitute poor, persons with disabilities and pregnant and lactating mothers. An interim assessment carried out in 2006[15] suggested that PATH had slightly improved school attendance and significantly improved by 38% health clinic visits for children 0-6 years. PATH' s overall impact on poverty has not yet been assessed. PATH now targets 360,000 beneficiaries, up from 236,000 in 2006. By December 2008, 85% of this number had been registered.[16] A Steps-to-Work programme to support poor households in seeking and retaining employment is now being piloted. From 2002 to 2007 approximately US$120M has been spent on PATH, including a US$40M World Bank loan.

Poverty rates are highest in the rural areas (15.3% in 2007, compared with 6.2% in the Kingston Metropolitan Region and 4% in Other Towns[17]) and have shown the slowest rate of decline over time. One method of facilitating economic empowerment in rural areas is through the provision of security of land tenure because lack of registered titles, a critical form of collateral, is a major factor impeding the development of the rural economy. The Land Administration and Management Programme (LAMP), a comprehensive attempt by the Government of Jamaica to title unregistered lands, is being gradually rolled out across the country and to date is in almost half the parishes.

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[13] Vision 2030 Jamaica-National Development Plan, (Planning Institute of Jamaica, 2009).

[14] *Economic and Social Survey Jamaica, 2008 (ESSJ)* Planning Institute of Jamaica.

[15] D. Levy, *Findings from Impact Evaluation of Jamaica's PATH Programme.* (Mathematica Policy Inc. for Ministry of Labour and Social Security, July 2006).

[16] *ESSJ, 2008.*

[17] *Jamaica Survey of Living Conditions 2007* (Planning Institute of Jamaica, 2008).

Development in the rural areas also needs to involve diversification of economic activities, and the upgrading of social and economic infrastructure.

Education (MDG 2)

TABLE 2 - GOAL 2: Achieve Universal Primary Education				
Target	**Indicators *(source)***	**1990**	**2000**	**2007**
2a.	2.1 Net Enrolment Rates in Primary Education	n/a	93.8%	90.2%
	2.2 Proportion of pupils starting grade 1 who reach grade 5 in primary (penultimate grade) *(Ministry of Education)*	n/a	88.3% 92.61M84.1	94.2% F97.6/M91
	2.3 Literacy rate of 15-24 yr olds *(1999 Min. of Education, 2007 UNESCO Inst. for Stats)*		91.6% (1999)	94.3%

Access to primary education has been achieved with almost 100% net enrolment at the early childhood level and 90% at primary level. The country has yet to meet the target of universal education at the secondary level where enrolment is 86% in the first three grades (7-9) but only 63% in grades 10 and 11, indicative of inadequate completion rates. Gross enrolment at tertiary level is 31%. Tuition is free at primary but not at early childhood level except in the few public infant schools (6% coverage).The Government instituted free tuition at secondary level in 2007 and has set 2016 as the target date for universal enrolment at this level. Fees in tertiary level institutions are subsidized and a government student loan scheme is available.

Complementing the education system is an effective training system, the Human Employment and Resource Training-National Training Agency (HEART/NTA) Trust, regarded as the standard bearer for the Caribbean and other developing countries.

The challenge of equity and quality

Jamaica's challenge is equity, the provision of quality education for all children. The society has been burdened with the vestiges of an inequitable two tier education system. As a result the quality of education at different schools has varied widely. The differences in performance are explanatory: in 2007 in the external Grade Six Achievement Test (GSAT), which decides selection to the upper or lower tier at secondary level, the average score in Language Arts for government primary schools (attended by over 90% of students) was 48% compared with 72% for private preparatory schools; the respective average scores for Mathematics were 46% and 70%. In 2006, at the end of secondary school, passes from the eligible cohort in upgraded public high schools (attended by 66% of students) in external Caribbean-wide English Language exams were 11% compared with 62% from the upper tier of traditional public high schools. The respective results for Mathematics were 4% and 41%.[18]

[18] *Jamaica 2015: National Progress Report 2004-2006 on Jamaica's Social Policy Goals* (Jamaica Social Policy Evaluation, a Project of the Cabinet Office, 2008).

These latter results, which compare poorly with other CARICOM countries, also highlight the generally poor outcomes of the secondary school system, a serious impediment in the preparation of young people for tertiary level education, for the job market and generally for economic and social development. Currently 74% of the labour force has neither certification nor training.[19] These poor outcomes are borne out by the negative experience of tertiary level academic institutions and employers and suggest that the overall youth literacy rate can be a deceptive MDG 2 indicator for countries at the medium level of development. Functional literacy rates would give a more realistic and meaningful picture, since basic literacy is not appropriate for their job markets.

Education transformation

In October 2003, a unanimous Parliamentary Resolution was passed to incrementally increase the budgetary allocation to the Ministry of Education (MOE) to 15% of the total within five years. This has not yet been achieved and stood at 12.6% in the 2009/10 Budget due to fiscal constraints. A Task Force on Educational Reform was established, with a wide remit. Consultations with citizens and experts throughout the country led to a report which analysed the inequities and major problems in the system and provided clear recommendations, including the significant expenditures needed to transform the education system. These included an injection of approximately US$630 million in capital and recurrent expenditure in the first two years. Thereafter, the annual recurrent budget of US$491 million should be increased to US$770 million and total capital expenditure from 2005 to 2014 should total US$1.1 billion. To initiate the transformation an additional US$73 million was added to the education budget in 2006/07.

Under the Education Transformation Programme, areas of focus include:

- Expansion of school facilities and infrastructure
- School leadership and management
- Literacy and numeracy at the end of primary school
- Poor attendance
- Low levels of teaching resources and aids
- Violence and anti-social behaviour
- Low levels of teacher training at early childhood level

[19] *Labour Force Statistics 2007* (Statistical Institute of Jamaica).

Child rights

The Government recognizes the importance of early childhood (0-8 years) development for successful education outcomes. An Early Childhood Commission was established and an Early Childhood Act passed with standards set for early childhood facilities. A major project is now being implemented with World Bank support to implement the new thrust for comprehensive provisioning to meet early childhood requirements. This focus is also seen as one of the critical long term answers to the problem of violence in the society, since research has firmly established that patterns of violence and aggressive behaviour in adolescents and adults can be traced to behavioural and social problems in early childhood.

These and other initiatives are in keeping with Government's commitment to the Convention on the Rights of the Child. For example, the Child Care and Protection Act was passed in 2004, which strengthens the care and protection of children by introducing new standards for their treatment. An important provision of the Act makes not just the state but every citizen accountable—responsible for reporting if they know or suspect incidents of child abuse and punishable by law if they do not comply. Under the Act, the Office of the Children's Advocate (2005) was established to promote the safety, best interests and well-being of all children under 18 years, and to enforce their rights by investigating complaints and acting in legal matters on their behalf. Additionally, the Children's Registry (2008) was set up to facilitate the mandatory reporting of abuse.

Gender (MDG 3)

TABLE 3 - GOAL 3: Promote Gender Equality and Empower Women

Target	Indicators *(source)*		1990	2000	2007
3a.	3.1 Ratios of girls to boys in:	primary education	0.99	0.96	0.96
		secondary education	1.07	1.03	1.02
		tertiary education	1.26 (est.)	2.06	1.98
	(Ministry of Education)				
	3.2. Ratio of literate females to males 15-24 years old			1.1	1.07
	(1999 MM. of Education, 2007 UNESCO Inst. for Stats)			(1999)	
	3.3 Share of women in wage employment in the non-agricultural secto.		38.3%	37%	48.9%
	(Statistical Institute of Jamaica)				
	3.4 Proportion of seats held by women in the national parliament		5%	12%	13%
	(Electoral Office)				

Overall, Jamaica's MDG gender record shows an uneven picture. Despite the long record of active political party membership, women have low levels of political power

and leadership. Levels of representation in the Senate (14%) and in local government (16%) are slightly better than in Parliament (13%).[20]

Women's unemployment rate is more than twice that of men (14.5% cf. 6.2% for men in 2007), despite the fact that they outnumber men 2:1 in tertiary education.[21] This is partly due to a greater number of unskilled jobs available for men. Nevertheless some Jamaican women have made substantial gains in the labour market where a few occupy visible positions of leadership—Leader of the Opposition, Chief Justice, Director of Public Prosecutions, Financial Secretary, Auditor-General and Chief Medical Officer, and women account for 54% of Permanent Secretaries in Ministries. Some head prominent, successful businesses and have been elected to lead national private sector manufacturing and employers' groups. Young women have found increasing employment in the services sector, particularly in call centres and data processing services and in an expanding tourist sector, while there has been decreasing female employment in agriculture due to the decline in the sugar and banana industries. Empowerment fails in areas of violence against women where domestic violence and sexual violence continue to be significant.

The gender gap in education begins to appear in the primary completion rate which is 97.6% for girls and 91% for boys. Women have a higher literacy rate than men (91.1% to 80.5% in 2007)[22] and girls outperform boys at every level of the education system. Research shows that socialization in the home along rigid gender stereotypical lines produces different educational outcomes for girls and boys. For boys, male privileging prevails whereby boys are given less tasks and responsibilities and allowed to go outside with limited supervision, whereas girls are given domestic chores and kept inside. Such patterns are manifested in the education system whereby girls are more prepared to handle routine and responsibility than boys.[23] Additionally, the notion of the male as primary economic provider and male perceptions of the irrelevance of the education system to existing labour market opportunities (including the informal economy and illegal activity) also push young men into earning at an early age. Within the school system causes are thought to include pedagogy, the traditional bias towards academic subjects and the social stigma still attached to skills training geared to boys, and the gender bias of some teachers exhibited in more punitive measures towards boys.[24]

[20] National Gender Task Force, 'Sector Plan for Vision 2030' (PIOJ).

[21] Ibid.

[22] UNESCO Institute for Statistics.

[23] Odette Parry, *Male Underachievement in High School Education in Jamaica, Barbados and St. Vincent and the Grenadines*, (2000); Barbara Bailey, "Gender and Education in Jamaica: What About the Boys?", *Education for All in the Caribbean: Assessment 2006* (UNESCO monograph series).

[24] Ibid.

A focus on public health

Overview

Jamaica ranks high among developing countries in the health status of its population, the result of well developed primary health care (PHC) infrastructure which reaches deep into rural areas, based on a policy decision taken in 1977 prior to the Alma Ata Meeting. The country has a record of providing good health at a low cost. Jamaica and the rest of the Caribbean was the first region in the world to eradicate poliomyelitis and measles. The continuing strength of the public health system was demonstrated at the end of 2006 during an outbreak of malaria, which was swiftly and successfully managed. Malaria was long eliminated but was imported by a refugee influx. It resulted in 191 cases but no deaths (Table 6). At the same time, while it performed well in this emergency, the primary health care system is threatened by staff shortages, as well as by lack of equipment in some health centres. The system is severely short of public health nurses and midwives, at 53% and 54% of the cadre, respectively with an annual attrition rate of 15%, as well as of pharmacists and community health aides. Registered nurses are 74% of the cadre.[25]

THE HEALTH TEAM

The primary health system recognizes the health team as important to service delivery. The health policy states that *"No highly trained person should spend time routinely doing tasks that could be undertaken by a lesser trained person."* Hence new cadres of health workers such as the Community Health Aide (CHA), Nurse Practitioners, Psychiatric Aid, Pharmacy and Lab Technical Assistants, Peer Educators, Contact Investigators, Behaviour Change Communication Agents, Psychologists as well as social workers have been introduced. **This is considered a best practice.** The innovation of CHAs has served to bring health closer to the community and has contributed to Jamaica achieving its health status. CHAs provide health education, monitor the elderly, facilitate immunization, and have been pivotal in nutrition education and other interventions.

The Ministry of Health (MOH) is now preparing a framework for a renewed primary health care strategy and has earmarked funding for the first phase. This framework is necessary to promote sustainability, quality and cost effectiveness against the background of a changing health landscape where migration of the health workforce is a major challenge, and disparities exist in training, medical education and distribution of human resources. The four key strategic areas of the renewed PHC model focus on strengthening leadership, the information system, health financing and human resources.

PHC in Jamaica has contributed to meeting the Millennium Development Goals. It has been responsible for high levels of immunization and an antenatal care programme which includes high risk antenatal care and ensures that over 98% of mothers have at least one antenatal visit and over 87% have four (Table 5). More than 90% of women attending antenatal clinics are now

[25] Ministry of Health, *Strategic Framework for Safe Motherhood within Family Health Programme 2007-2011* (April 2007).

tested for HIV. With the introduction of antiretroviral treatment the mother to child transmission rate was brought below 10% by 2007.

Family planning programmes under the National Family Planning Board have been very successful in reducing the fertility rate from 4.5 children per woman of child-bearing age in 1975 to the present 2.5. United Nations agencies such as PAHO, UNICEF and UNFPA have provided critical support in health areas related to women and children, the latest being the joint Safe Motherhood Programme.

Chronic non-communicable diseases, malignant neoplasms and injuries

The epidemiological transition is advanced here with chronic non-communicable lifestyle diseases (NCDs), malignant neoplasms, violence, and intentional and unintentional injuries responsible for most deaths. This profile mirrors that of developed countries. Over the period, 2000-2008, the prevalence of diabetes increased to 7.9% from 7.2%, of hypertension to 25.2% from 20.9, and of obesity to 25.3% from 19.7%.[26] The Government has developed a National Policy and Strategic Plan for the Promotion of Healthy Lifestyles to tackle the increasing prevalence of these NCDs along with cervical and prostate cancer, and the prevention of violence-related injuries, the last now a significant and very costly public health problem. This policy will be achieved by focusing on preventable behavioural risk factors which for chronic disease includes physical activity, appropriate eating prevention and control of smoking. While the country has made significant gains, the challenge is to find culturally effective interventions that will lead to positive behaviour change.

PROVISION OF SUBSIDIZED DRUGS

A recent success of the health system has been the provision of subsidized drugs through the National Health Fund (NHF) established in 2003, and sustainably financed through an excise tax on tobacco and by the National Insurance (NIS) Fund. The NHF was created to provide institutional financial support to the public health system, including resources for PH emergencies (e.g. hurricanes, dengue 'threat'), prevention of NCDs, infrastructure development and institutional benefits. It provides drugs for 15 medical conditions with a small flat dispensing fee (US45 cents) for the elderly and a subsidy of over 80% for the rest of the population (Table 8). These drugs from the VEN (vital, essential and necessary) list cover both generic and non-generic. Private pharmacies, skeptical at first, have now bought into the system with the great majority involved. It has an electronic health record system with 400 000 chronic disease patients across the country.

Dealing with intentional and unintentional injuries has resulted in reallocation of staff, shortage of blood supplies and disruption in scheduled operations. An analysis of the economic costs of injuries due to interpersonal violence in Jamaica in 2006 assessed the

[26] R. Wilks, N. Younger, M. Tulloch-Reid, S. McFarlane, D. Francis, *Jamaica Health and Lifestyle Survey 2007-2008* (Epidemiology Research Unit, University of the West Indies and the National Health Fund, Dec 2008).

direct medical costs (approximately US$31.8M) to account for about 12% of the country's total health expenditure, while indirect costs (approximately US$416M) account for about 4% of GDP.[27] Jamaica's health profile also reflects this major national problem. Overall, homicide is the fifth leading cause of death in Jamaica. The four leading causes of death for men are cancer, homicides, heart disease and cerebrovascular diseases; for women they are cancer, cerebrovascular diseases, diabetes and heart disease.

Mental health

Twenty-six per cent of women and 15% of men suffer from depression.[28] Government has undertaken a process of decentralization of mental health services to provide accessible, comprehensive, community-based mental health services, including island wide child guidance clinics. A framework and work-plans for this decentralization have been developed, and resources are urgently needed for implementation.

HIV/AIDS

It is estimated that, as of 2007, 25,000 persons, or approximately 1.3% of the adult population, are HIV infected and that almost two-thirds of this group are unaware of their status. The last three to four years have also seen the first decline in AIDS deaths and AIDS cases by 38% and 30% respectively.[29] This is due to: (i) the increase in access to antiretroviral drugs from less than 5% in 2000 to 60% in 2008 (Table 6), provided free of charge to public sector patients and at greatly reduced prices for private patients through the NHF with Global Fund assistance; (ii) prophylaxis against opportunistic infections; and (iii) improved laboratory capacity to conduct investigations, resulting in a general improved quality of care.

It is also the aim of MOH's dynamic multi-faceted programme to combat the AIDS epidemic, recognizing it to be a development concern as well as a health issue. This has included:

- policies to guide the management of HIV/AIDS within educational institutions, the workplace (increasingly implemented in the private and public sectors), and for orphans and other children made vulnerable by HiV/AIDS;

[27] E. Ward and A. Grant, "Estimating the economic costs of injuries due to interpersonal violence in Jamaica" In *Manual For Estimating the Economic Costs Of Injuries Due to Interpersonal and Self-Directed Violence (Geneva:* World Health Organization, 2008).

[28] Ibid.; R. Wilks, et al., *Jamaica Health.*

[29] *ESSJ 2007 and ESSJ 2008.*

- community outreach programmes, including outreach to sex workers;
- the Mother-to-Child Transmission programme; and
- effective behaviour change, communication and public education programmes, including street demonstrations of condom use and mass media advertisements.

HOSPITAL-BASED CHILD ABUSE MITIGATION PROJECT

From 2004 to 2008 an experimental Child Abuse Mitigation Project (CAMP) was set up in the national children's hospital for 0-12 year olds. It had three objectives:

1. To develop and implement a hospital-based model to identify and refer victims of violence

2. To improve parenting skills and conflict resolution

3. To develop and implement an intervention model within the child's environment (home, school, church) through interaction with existing community based programmes

A small staff of social workers and one psychologist investigated 1 284 cases (4 per 1,000) referred from the Accident and Emergency Department as suspected victims of physical abuse, sexual abuse or with gunshot wounds. Staff would investigate, visit homes, give immediate counseling and refer when necessary. Parent education sessions and attendance of selected clients at weekly and summer art, music and recreational camps to effect the building of life skills and create a healing space were included. Set up by the MOH in collaboration with UNICEF, **it was recently assessed as a best practice model, the only one of its kind in the English-speaking Caribbean**. It was successful in its first objective and partially in the others, due to human and financial constraints. There are plans to restart it and replicate it in other hospitals.

This work is supported by ongoing research: reproductive health surveys, knowledge, attitudes, behaviour and practice surveys, as well as specific topic and area focused studies.

Financing health care

Since May 2007, health care at the 340 public health clinics and the 23 public hospitals (excluding the university teaching hospital) has been free to all children under 18 years, and, since April 2008, to the general public, abolishing user fees introduced previously as a cost sharing measure. According to several rounds of an annual household survey, despite explicit exemption for the poor, this approach was impeding one in five persons from accessing health care.

Financing health service delivery is a major challenge as the current expanded demand on the resources, combined with the human resource constraints from migration of health personnel, can potentially overwhelm the primary care delivery process. Jamaica spends between 4 and 5.5% cent of the national budget on health care (the recommended proportion is 10-15%) and at the same time does not qualify for much donor funding as it falls in the lower middle income country category.

The NHF utilizes a creative model of taxation, "sin taxes", and is considered a health financing best practice. It could be replicated with items such as alcohol and selected junk foods, using that income to create institutional capacity to focus on prevention of

disease. Jamaica is currently exploring other health financing opportunities through public-private partnerships.

Child survival (MDG 4)

TABLE 4 - GOAL 4: Reduce Child Mortality				
Target	**Indicators *(source)***	**1990**	**2000**	**2007**
4a.	4.1 Under-five mortality rate	29.5/1,000 (1993)	25.4/1 000 (1998)	25.4/1 000 (2005)
	4.2 Infant mortality rate *(Statistical Institute of Jamaica)*	24.4/1,000	21.3/1 000 (1998)	21.3/1 000
	4.3 Proportion of 1-year-old children immunized against measles (immunized up to 23 months old)* *(Ministry of Health)*	74%	88.1%	87.2% (2006)

* *Jamaica was measles free until a 2008 contact of an imported case. Since then there have been no further reports. The measles vaccination is usually given between 12 and 23 months.*

Historically, Jamaica has had an outstanding record for immunization but in recent years coverage has dipped for BCG, OPV, and DPT from the 2002 high where all vaccine coverage rates exceeded 90%. Contributing to this problem are:

- a severe shortage of public health nurses and midwives in most parishes resulting in Immunization Clinics being compromised;
- schools accepting children without full immunization. This can be eliminated with improved inspection;
- insufficient Community Health Aides, who assist in monitoring immunization status and identifying and referring children not immunized, as well as educating parents and caregivers; and
- young parents who have never seen these preventable diseases and do not take their children for vaccination when they are otherwise well.

Financial and human resource constraints impact performance against the MDG targets for infant, child and maternal mortality in particular. There are unresolved data management issues with regards to measuring child and maternal mortality. Therefore, while estimates exist, their validity is uncertain.[30] Nevertheless, existing data indicate that the majority of infant deaths occur during the neonatal period. Reductions will require expanding neonatal care services and must take cognizance of the increasing

[30] Data discrepancies exist in both Infant Mortality and Maternal Mortality estimates. A Vital Statistics Commission has been established by the Government to ensure the production of estimates on vital statistics that meet international standards and, with support from international partners, measures are being put in place to address the data management issues.

disability rates that accompany survival of the very preterm infants, with plans made to provide support services to address the needs of these infants. The National Early Childhood Strategic Plan is expected to expand screening and service delivery to the 0-3 year population through public health clinics, targeting 30% of health centres in order so as to offer high quality well child services by 2011.

Maternal health (MDG 5)

TABLE 5 — GOAL 5: Improve Maternal Health

Targets	Indicators *(source)*	1990	2000	2007
5a.	5.1 Maternal mortality ratio	120/100 000	94.8/100 000	n. a.
	(McCaw-Binns et al. 2007 and Planning Institute of Jamaica)	(1986-87)	(2001)	
	5.2 Proportion of births attended by skilled health personnel	95%		96.8%
	(Ministry of Health)	(est.)		(2006)
5b.	5.3 Current contraceptive use among women in union* (15-49 yrs old)		65.9% (1997)	69% (2002)
	5.4 Adolescent fertility (15-19 yrs)		112/1 000 (1997)	79/1 000 (2002)
	5.5 Antenatal care coverage:			
	at least one visit		99%	98.1% (2002)
	at least four visits		87.2% (both 1997)	n/a
	5.6 Unmet need for family planning (women 15-44 yrs)	16.1%	9.0 4%	8.5%
	(National Family Planning Board)	(1989)	(1997)	(2002)

* *in union = in a married, common-law or visiting relationship*

One critical factor slowing the rate of reduction in maternal mortality has been the impact of NCDs. While deaths from direct causes declined by 49% between 1987 and 2006 due to improved health management and improved access to obstetric care, over the corresponding, there was an 83% increase in deaths from indirect causes, negating these gains. The incidence of HIV/AIDS in the antenatal population has been a significant factor as well as morbidity from hypertension; heart disease (now the second leading cause of maternal death) and diabetes, often associated with obesity even in young mothers.

A factor affecting the monitoring of maternal mortality is the need for accurate and consistent measurement. To date, no data has been available since 2001 due to unresolved data management issues. However, based on available data, severe shortage in the cadre of midwives is another critical component. Maternal mortality rates will not be improved unless the resources are found to train and retain adequate numbers of midwives and manage the flow of nursing personnel to developed countries.

Reproductive health, adolescent sexual health, fertility and sexual knowledge, attitudes and practices are extremely important and impact on MDGs in health, education and poverty reduction.

The adolescent fertility rate is still very high, although from 1997 to 2002 it reduced significantly (Table 5). Twelve per cent of sexually active 15-19 year old females have had between two to three pregnancies. With respect to HIV/AIDS, adolescent females 10-14 years face twice the risk and those 15-19 years three times the risk of contracting the disease, due to transactional sex, forced sex and sex with older HIV infected male partners.

THE WOMEN'S CENTRE OF JAMAICA FOUNDATION

Given the correlation between maternal and child health and the education of women improvements in the educational system should have a positive impact on this goal in the long-te m. In the cause of the continuing education of adolescent mothers, the Woman's Centre of Jamaica Foundation, with seven centres across the island, operates a very successful programme, educating them when they leave school during pregnancy, training them to care for their babies immediately after birth, and assisting them to re-enter the formal school system to complete their education. The young fathers (this is the usual pattern) and the families of both parents are included in the centres' outreach. Starting as an NGO and now under the Ministry of Youth, Sport and Culture, they have assisted over 35 000 teenage mothers since 1978. Tracer studies have demonstrated their success in halting the mother to daughter cycle of adolescent pregnancies.

Influencing sexual decision-making among youth has become extremely important, not only in relation to STIs and early pregnancy but also from a human rights perspective of personal choice and control. Pre-teen and teenage girls are a vulnerable group. Many are not sufficiently empowered to resist male advances or to insist on safe sex practices. In a recent school- based survey of 10-15 year olds,[31] of the 6% of girls who reported they had had sexual intercourse, an alarming quarter stated they had been forced. In a parallel community-based survey of 15-19 year olds,[32] 48% had had sexual intercourse and one in five reported being forced.

[31] K. Fox, and G. Gordon-Straughan. *Jamaica Youth Risk and Resiliency Behaviour Survey 2005.* (USAID/MEASURE Evaluation/Ministry of Health, Mar 2007).

[32] R.Wilks, N. Younger, S. McFarlane, D. Francis, and J. Van Den Broeck. *Jamaica Youth Risk and Resiliency Behaviour Survey 2006.* (University of the West Indies/USAID/MEASURE/Min. of Health, Nov 2007).

Combating HIV/AIDS, malaria and tuberculosis (MDG 6)

The primary mode of transmission of HIV infection is through heterosexual sex (71%). The main reported risk factors for HIV/AIDS infection in Jamaica are multiple sex partners (around 80%), a history of STIs (51%), sex with sex workers (24%), men who have sex with men (14%), and crack/cocaine use (8%).[33]

Despite progress there is still much further to go in terms of the effective education of young people and the pursuit of the struggle against stigma and discrimination, which have proven to by some of the strongest obstacles in the battle against the HIV/AIDS epidemic.

Vector control to prevent the re-emergence of previously controlled communicable diseases has emerged as a new challenge. Better management of garbage and improved hygiene has become increasingly important. Since November 2006, Jamaica has been affected by a two malaria outbreaks with confirmed local transmission leading to a cumulative total of 386 cases by the end of September 2008. The MOH has brought the situation under control through intensified surveillance, public awareness and health education, strengthened laboratory capacity, improved vector control, early detection and case management. The increased workload to control the outbreak has placed additional strain on limited health resources. A National Malaria Control Strategic Plan is due in May 2009. There is also a National TB Control Strategic Plan focused on increasing access to TB diagnostic and treatment services across the island, which will be finalized by June 2009.

[33] Ministry of Health, National HIV/STI Programme. *Jamaica HIV/AIDS Epidemic Update Jan – Dec 2007.*

TABLE 6 - GOAL 6: Combat HIV/AIDS, Malaria and Other Diseases				
Targets	**Indicators *(source)***	**1990**	**2000**	**2008**
6a.	6.1 HIV prevalence among population aged 15-24 yrs		1.4% (est.)	1.3% (est. 2007)
	6.2 Condom use at last high-risk sex*: men		77.3%	83.5%
	(age 15-24 years) women		71.7%	66.3%
	6.3 Proportion of population aged 15-24 yrs with comprehensive correct knowledge of HIV/AIDS: men		29.6%	37.4%
	women		33.4%	42.3%
	6.4 No. of children orphaned by AIDS *(Ministry of Health)*			8 000 (est.) (1986-2007)
6b.	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs *(Ministry of Health)*		<5% (est.)	60%
6c.	6.6 Incidence of malaria (imported prior to 2006)	0	7	191
	Deaths associated with malaria	0	0	0
	6.9 Incidence of tuberculosis	123	120 (2003)	98 (2006)
	Deaths associated with tuberculosis	n/a	24 (2003)	16 (2006)
	6.10 Proportion of tuberculosis cases detected & cured under directly observed treatment short course *(Ministry of Health)*	n/a	45 (2003)	77 (2006)

** Definition of high risk in 2000 (= partner < 12 months) differed from definition of high risk as of 2008 (non-marital, non-cohabiting partner) making comparison difficult.*

Environmental sustainability (MDG 7)

TABLE 7 - GOAL 7: Ensure Environmental Sustainability				
Targets	**Indicators *(source)***	**1990**	**2000**	**2007**
7b.	7.1 Proportion of land area covered by forest *(Forestry Department)*	30.6% (1989)	30.1% (1998)	30.6%
	7.2 CO_2 emissions: total (000 metric tonnes)	7 963.16	10 396.91	10 591.88 (2004)
	per capita (metric tonnes)	3.36	3.98	3.97 (2004)
	7.3 Consumption of all ozone depleting substances (ODP metric tonnes) *(UN MDG website)*	431	69.5	2.5 (2006)
	7.4 Proportion of fish stocks within safe biological limits *(Ministry of Agriculture)*	n/a	n/a	n/a
	7.5 Proportion of total water resources used (total reliable yield) *(Water Resources Authority)*	22.36%	35.19%	38.3%
	7.6a Proportion of terrestrial area protected in relation to total surface area	8.2% (est.)	n/a	n/a
	7.6b Proportion of marine area protected in relation to total territorial waters *(UN MDG website)*	0%	3.6% (est.)	3.6% (est.)
	7.7 Proportion of species (plants) threatened with extinction *(National Environmental Protection Agency)*	n/a	n/a	18.6% (2003)
7c.	7.8 Proportion of population using an improved drinking water source	**91.7%** (61.2%*)	**91.5%** (66.6%*)	**91.7%** (70.2%*)
	7.9 Proportion of population using an improved sanitation facility *(Planning Institute of Jamaica)*	**99.1%** (51.4%**)	**99.8%** (62.2%**)	**98.9%** (64.3%**)
7d.	7.10 Proportion of urban population living in slums*** *(UN MDG website)*	29.2% (est.)	35.7% (est. 2001)	60.2% (est. 2005)

N.B. The MDG definition of an improved drinking water source includes rainwater.

** Piped water at home (indoor or private outside).* ***Use of water closet (exclusive or shared).*

**** Estimation based on two components, water & sanitation for 1990 & 2001 (UNICEF/WHO). Three shelter components (water, sanitation & sufficient living) from MICS 2000 were used to estimate 2005 slum dwellers.*

Jamaica's developmental strategies have been heavily focused on fostering economic growth, using the private sector as the primary vehicle for undertaking the related economic activities of tourism, mining, agriculture and manufacturing. In the past, this has resulted in sectoral policies not effectively taking account of environmental

considerations and consequently causing degradation of the natural environment, while local authorities often ignored breaches of environmental regulations.

The island's score for ecosystem vitality in the 2008 Environmental Performance Index (EPI) is 71%, the regional score being 72%, and the comparative income group 69.4%. Overall, Jamaica ranked 54 out of 149 countries in the EPI. The weakest area for Jamaica was in the biodiversity and habitat category where the score was 35, compared with the regional score of 43.2 and the global comparative income group score of 48.6. The variations in the specific indicators and scores are telling: conservation risk (66.4%), effective conservation (28.6%), critical habitat (40%), and marine protected areas (5%).[34]

Beaches, wetlands and coral reefs, the irreplaceable breeding grounds for fish and marine life as well as protection against the impact of hurricanes, are threatened by land-based pollution and natural factors such as global warming. Thirty per cent of mangrove forests have been lost and the Centre for Marine Sciences of the University of the West Indies' monitoring of coral reefs indicates that whereas nine reefs on the north coast had coral cover averaging 52% at 10 metre depth in the late 1970s, in 2005 the cover was between 0% and 34%. The reefs of the north western coast are under severe pressure from high levels of nutrients, including critical concentrations of nitrogen and phosphorus, discharged into coastal and fresh water sources by tourism related developments, human settlements, and excessive fertilizer use from farms.[35]

SELECTION OF POLICIES AND PROGRAMMES SUPPORTING ENVIRONMENTAL SUSTAINABILITY

- **Policy interventions for funding**: Support to environmental management by NGOs using debt-for-nature swaps for the establishment and operation of the Environmental Foundation of Jamaica and the Forestry Conservation Fund (FCF).
- **Co-managing natural resources.** Developing community-based income generation projects in sustainable use of forestry reserves co-managed by an NGO, Jamaica Conservation Development Trust.
- **Effective management of protected areas as well as new priority sites** identified in the ecological gap assessment: the target is 20% of Jamaica's marine and terrestrial area by 2015 (made at the 9th Conference of the Parties to the Convention on Biological Diversity)
- **Establishment of fish sanctuaries**
- **Target for moving renewable energy from the current 5% to 15% of the energy mix by 2020.** The introduction of cheaper E10 fuel, a blend of 10% ethanol from sugarcane and 90% gasoline, enthusiastically taken up by drivers.
- **Investment in a wind energy farm**, the Wigton Wind Farm, a Clean Development Mechanism project under the Kyoto Protocol, by the government-owned Petroleum Corporation of Jamaica.
- **Co-generation Power Project,** started by GOJ, which aims to produce and utilise petroleum coke (petcoke), a low cost clean coal technology, to generate electricity.
- **An Environment Management Systems (FMS) policy,** now at draft stage, for further standardization of, and compliance with, sustainable development initiatives, such as the use of solar energy in the tourism sector.
- **A draft Climate Change Action Plan** is being developed from Jamaica's 2nd National Communication on Climate Change.

The multiple indicators under this goal (Table 7) demonstrate its broad reach. Jamaica's rich environmental resources are treasures that make an immeasurable contribution to the quality of life of all its citizens. Reversing biodiversity loss is, nevertheless, very challenging in the short term for Jamaica as a SID state that is dependent on its rich environmental resources for the development of its two largest foreign exchange earners (excluding remittances), tourism and bauxite.

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[34] *Vision 2030 Jamaica - National Development Plan* (Planning Institute of Jamaica, 2009).

[35] Ibid.

Additionally, even where we have the regulatory legislative framework, we have serious enforcement capacity gaps.

New directions, diversifying sources of wealth and being more environmentally friendly in approach, would include greater investment in sports, cultural and fashion industries; in the development, use and export of environmental technologies; in nutraceuticals and medicinal products from the rich plant life; and more agro-processing of high quality agricultural products for niche markets.

Sustainable development through policy coherence

There is a lack of integration of principles of sustainable development into policies and programmes. Failure will erode the quality of life in the medium to long-term, including prospects of economic prosperity. Strategic environmental assessment (SEA) of policies and programmes is one means of addressing policy coherence. It is also essential to design a coordinating mechanism dedicated to monitoring sustainable development.

Energy use

Because of its 90% dependency on oil for energy, Jamaica's CO2 emissions are rising on an annual basis (Table 7). Jamaica has one of the highest energy intensity rates in Latin America and the Caribbean. This has been due largely to the high-energy use of the bauxite and alumina and water sectors. Additionally, an inefficient public electricity system and inefficient outdated energy technologies put Jamaica at a competitive disadvantage. Diversification of energy sources represents a priority for the future development of the energy sector.

Water and sanitation

Water and sanitation indicators appear to be unchanging because of the difficulty in halving the gap when since 1990 access to safe drinking water has been over 91% and to basic sanitation over 99% (Table 7).

With regard to water, there is a significant difference between the rural areas, with only 86% of households accessing safe drinking water, and Other Towns and the Kingston Metropolitan Area with 95% and 97% access respectively. Quality improvement in water access, with a target of 85% receiving piped water to their dwelling by 2015, has been a focus. Over the period, the proportion of the population with piped water to their dwelling has increased to 70%. Improved water sources is a critical target for the 9% without safe drinking water and improved access is important for the 1.5% of households whose members have to carry water for distances of 50 to over 1,000 metres. The majority are women and children. The remaining gap in this area is being addressed by the Ministry of Water and Housing's Rural Water Supply agency, which harnesses small streams, rivers, and springs to supply isolated communities. It

also organizes public trucking of water. The promotion of private sector partnership has resulted in eight licences being issued to private companies to supply potable water.

With regard to basic sanitation quality improvement, enabling universal access to water closets has been a focus, and over the period the proportion of the population with water closets has increased by 13 percentage points to 64%. Increased attention is now being paid to upgrading sewage plants, cleaning drains and improving garbage collection in order to combat pests, improve vector control and to mitigate damage from natural disasters.

Urban housing conditions

The slippage that has occurred in the target of improving slums is of great concern. Jamaica's urban population has grown to 52% of total population in 2001[36] from 35% in 1991. Much of this growth is the result of rural-urban migration and in some areas, especially in the two major cities and transport corridors, has resulted in overcrowding, the growth of squatter communities and increasing stress on infrastructure and amenities unable to cope with the pressures of unplanned growth. Poor physical planning in the past has resulted in a myriad of problems evidenced by run-down town centres, urban sprawl, environmental degradation, unsafe and dilapidated housing, and planned and unplanned development in ecologically-sensitive areas. These problems are at their most acute in urban slums where high rates of malaria, dengue and leptospirosis were found in recent outbreaks. Infrastructural change, income-generating opportunities and social interventions are all needed simultaneously to reduce the high rates of interpersonal and gang violence associated with these communities.

The Jamaica Social Investment Fund (JSIF) has targeted 12 inner-city communities, employing 350 residents in infrastructure upgrading. These residents also receive on-the-job training certification from HEART/NTA.

An Inner City Housing Programme, by the National Housing Trust, including skills training and other capacity building programmes for prospective home owners, has built just over 1,000 units. However in 2008 the programme ended due to delinquent beneficiaries and other challenges, a serious blow to this effort. The problems include a culture of dependency in inner-city areas associated with a history of political patronage, and highlight the difficulties of this process and the need for a transformational approach. Alternative methods, requiring a more labour intensive construction process to employ inner-city dwellers may be needed. Planning and design phases may need to incorporate more citizen participation, like JSIF, which employs, trains and certify beneficiaries in the building phase. Mortgage payments would begin through wage deductions.

[36] *Population Census: Jamaica 2001* (Statistical Institute of Jamaica).

Although 81% of the population has secure housing tenure via ownership, rental or lease, a preliminary survey by the Ministry of Housing has found that almost a quarter of Jamaica's population are living as squatters on land they neither own nor lease, even though many own their dwelling. The Government has recently set up a squatter regularization unit and the Housing Agency of Jamaica, responsible for the provision of housing solutions, has started 600 lots in a very large squatter settlement on the outskirts of Montego Bay, Jamaica's second city

Developing a global partnership for development (MDG 8)

Jamaica's eligibility to access certain grant programmes has been reduced because of its categorization as a middle-income country and the geopolitical shift of resources towards the Middle East and sub-Saharan Africa. In addition, the areas of official development assistance have shifted away from preferential arrangements to trading relationships. The volume of grant funding from Multilateral Technical Cooperation agencies and some traditional bilateral donors has decreased, but loan financing has remained fairly stable. Assistance from several non-traditional bilateral partners has also increased and Jamaica has been successful in securing assistance from these and from multilateral sources.

On the demand side, Jamaica's capacity to absorb loans has been retarded by its already high debt burden and the consequent limit in fiscal space for social expenditure. While there have been constraints, the Government is seeking to ensure development objectives are advanced through more efficient portfolio management. As the country seeks to better manage its resources, development partners have assisted the Government through various types of disbursement (including budgetary support, and quick disbursing loans).

TABLE 8 - GOAL 8: Develop a Global Partnership for Development				
Targets	**Indicators *(source)***	**1990**	**2000**	**2007**
8a.	8.5 ODA received in Small Island Developing States in million US$ (net*) *(OECD)*	US$270.62M	US$9.98M	US$27.87M
	8.12 Debt service as a percentage of exports of goods and services and net income *(Planning Institute of Jamaica)*		10.47%	12.43%
8b.	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis *(Ministry of Health)*	n.a	n.a	n.a
8c.	8.14 Telephone lines per 100 population	4.46/100	19/100	12.96/100 (2008)
	8.15 Cellular subscribers per 100 population *(Office of Utilities Regulation/ Statistical Inst)*	0/100	14.13/100	100.9/100 (2008)
	8.16 Internet users per 100 population *(International Telecommunications Union)*	0/100	3.08/100	55.3/100 (2008)

**Loans plus grants minus repayments.*

The relationship between Jamaica and the Bretton Woods Institutions has matured over time. These institutions are providing an increasing level of budget support with conditionalities based on the country's own reform agenda. Nevertheless, the ability of Jamaica and other developing countries to negotiate more equitable terms and conditions is significantly limited.

Jamaica has also been highly successful in negotiating mutually beneficial arrangements with international telecommunication companies to bring affordable cellular technology to Jamaica, with penetration of over 100%, tangibly raising the quality of life across all classes (Table 8). The focus on the use of ICT within the educational system, as well as its wide use in the public and private sector, has resulted in a rapid increase in access over the past eight years with over half the population now having some level of internet access.

Through the NHF, Jamaica is providing universal access to subsidized VEN drugs for 15 chronic medical conditions and, with the valuable assistance of the Global Fund, free antiretroviral drugs.

Cross-cutting issues affecting the achievement of MDGs

Three issues of critical importance in relation to Jamaica's achievement of the MDGs are: the global recession, violence, and the plight of unattached youth.

Global recession

Given the early impact of the global recession on remittances, job losses and inflation, the poverty reduction rate is almost certainly not sustainable and is likely to regress. Food security will be very difficult, particularly for children and the elderly, as present importation of food (about 40% of consumption) costs US$750 million. Hunger will negatively impact school attendance, educational performance and health targets. Increased poverty is likely to have an impact on crime. It is also likely to lead to increased squatting as job losses impact on ability to pay rent and to increased deforestation,as more persons not only turn to using wood for domestic cooking but to burning charcoal as a highly marketable commodity.

The Government has put new emphasis on agriculture and fisheries and this sector is one of the few, other than education, with an increased allocation in real terms in the tightly constrained 2009/2010 budget. Increasing food production will be critical and more schools must engage in this where they have land. School feeding programmes will need to be strengthened in this and other ways.

Violence

In 2008, 1,618 persons were murdered, 77% of them died by the gun, including 165 women and 94 children. There were 2,232 cases of sexual violence, 57% of the victims were under 19 years old. The majority of the victims were female, while 29 males were also violated.[37]

All forms of violent conflict impact nearly every MDG. It causes poverty from this slowdown and closure of businesses, immobility, injury or death of a household head and the impact on remaining family members. Its aggregate impact on GDP has already been illustrated. Gender-based

SELECTED COMMUNITY SAFETY & SECURITY INITIATIVES

- The Peace Management Initiative (PMI), set up in 2002 by the Ministry of National Security (MNS),Includes representatives of both political parties and civil society, defuses explosions of community violence, follows with development initiatives and counseling.
- The Violence Prevention Alliance (VPA), set up in 2004 by the MOH. Has pioneered the use of GIS software to generate 'injury hotspots'. This is a best practice use of evidence manipulating datasets from different ministries (e.g., incidence of violence-related injuries, sanitation, levels of literacy) correlated across communities to provide critical insights for policy making and police operations.
- The Citizen Security and Justice Programme and the Community Security Initiative, two MNS programmes, address social development and security services in poor communities, sometimes with the assistance of contracted NGOs.

[37] *ESSJ, 2008.*

violence is profoundly disempowering for women's well-being and their levels of economic productivity. Violence affects education as schools have to close down or attendance is negatively affected. Trauma affects educational performance, mental and physical health and productivity. Violence eats into resources needed to reduce child and maternal mortality and other areas in health care.

Research has assessed injuries caused by violence to have consumed about 12% of the country's total health expenditure in 2006.[38] Jamaica has adopted a multi-faceted approach to tackling violence. This approach includes peace and conflict resolution in schools and communities, mediation, restorative justice, and victim-centred mechanisms. At a structural level, both the Police Force and the entire justice system are undergoing radical modernization and reform.

Unattached youth

Jamaica's working-age population (15-64 years) was estimated at 63.4% of the population in 2007 and is expected to peak at 67% in 2025. This "bulge" in the population of working age is regarded by demographers as a "window of opportunity". Youth are the group that should see the fulfilment of the Vision 2030 Jamaica-National Development Plan. It is therefore critical that their capacity is built. In light of their unrealized potential and their vulnerability, unattached youth are a particular concern. These are individuals aged 15-24 years who are not in school, unemployed, and not participating in any training course. This group accounts for roughly 30% of all youth.[39] About a quarter of unattached youths had attained only a grade 9 level or less of education. Of this age group, 26.2% males and 7.9% females are illiterate.[40] This makes female youth vulnerable to sexual exploitation and violence, and adolescent pregnancy and puts male youth in an extremely vulnerable position leading to participation in criminal gangs.

For development to be achieved, it is now understood that social infrastructure needs to be strengthened simultaneously with physical infrastructure development. This social development has to start with good parenting practices and early childhood education, and the ongoing building of resilience through promotion of healthy lifestyles, extra-curricular activities, after-school homework assistance, weekend and summer children and youth programmes, family life education, skills training, capacity building in conflict resolution, mediation and organizational skills.

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[38] E. Ward, and A. Grant. "Estimating the economic costs of injuries due to interpersonal violence in Jamaica" in *Manual for estimating the economic costs of injuries due to interpersonal and self-directed violence* (Geneva: World Health Organization, 2008).

[39] *ESSJ, 2008*.

[40] Jamaica Adult Literacy Survey, 1999.

Conclusion and recommendations

The immediate external challenge preventing Jamaica from making greater headway in the MDGs is its heavy debt burden. When the country spends so much on debt repayment, it is virtually impossible to make significant headway in tackling problems of educational transformation, youth vulnerability and urban decay. Improvement in these areas could have a significant impact on violence reduction, on economic growth and achievement of MDG targets. In addition the costs of improving environmental conservation and disaster mitigation, now more urgent in the face of climate change, cannot be ignored. With the added pressure of recession, deterioration in all of these areas seems inevitable. If this is to be prevented and if successful and critical interventions are to be maintained, let alone scaled up, more development aid is needed. Lessons from Jamaica's successes can help less developed countries; regression in its development would threaten the entire Caribbean region.

It is important that when countries move into the middle income category, their developmental progress is not threatened by a reduction in aid but the level of aid is sustained until the gains are consolidated. Otherwise it can appear as if countries are being penalized for doing well. In Jamaica's case, the criteria for funding and assistance do not recognize violence as vulnerability, in terms of the way in which high levels of violence thwart achievement in the MDG indicators. The criterion of middle income status does not seem to take into account Jamaica's reality: the level of violence, its fragile status as a SID, and its economic vulnerability.

Developed countries therefore need to ensure that the development process is supported by:

- Aid; and
- Other equally important mechanisms such as:
    - debt forgiveness;
    - debt equity swaps;
    - technology transfer;
    - support for regional and global partnerships and joint ventures – very small islands will always have limited capacity and these partnerships are essential;
    - foreign direct investment which promotes the development of domestic capital;
    - support for infrastructural development;

- support for anti-corruption initiatives; and importantly
- structured arrangements between donor and recipient countries to ensure benefits from migration – this applies particularly to health and education professionals.

With specific reference to the health sector the following is recommended:

- Policy support from the international community to ensure equitable access to health through improving capacity to finance the health sector;
- Financing at affordable, concessionary rates to stimulate renewal of primary care model;
- Partnerships with educational institutions to build capacity—expand training of health personnel;
- E-health: application of information technology to health
  - Health insurance
  - E-pharmacy
  - Tele-mentoring
  - E-radiology; and
- Capacity development to mobilize resources (human, economic, technical).

United Nations agencies have provided tremendous assistance to Jamaica. This assistance works best when the following issues are taken into account:

- *Country ownership of policies and programmes*. Effective contributions to public policy require a genuine willingness to listen to the input of developing country stakeholders and local experts and to take cognizance of cultural contexts for the most effective outcomes. There can be challenges when agencies wish to influence policy based on the experience of external consultants.
- *Policy directives from international gatherings do not come with economic support*. It creates challenges for countries to implement such directives. This is the case with some of the health MDGs, e.g., infant and maternal mortality.
- *Partnerships build national and regional capacity*. An example of this is the Caribbean Epidemiological Centre, which combined PAHO posts and national posts. It reported to PAHO but reflected Caribbean aspirations. The United Nations empowered the Caribbean Disaster Emergency Response Agency of CARICOM

when it agreed that CDERA did not need to go through the United Nations structure to raise funds, enabling it to keep the 18% administrative fees that formerly went to the United Nations. CDERA now approaches multilateral and other funders directly.

- *Projects are designed from the outset to lead to programmes*. This enables sustainability and ownership and builds local institutional capacity and reduces long-term external dependency. The success of United Nations agencies' strategic interventions needs to be an important part of their performance assessment, not just the level of funding disbursed.

- *A coherent harmonized sector-wide approach among United Nations agencies and multilateral agencies*. This will exponentially improve aid effectiveness.

Assistance that is enmeshed in layers of bureaucratic procedures is an obstacle to empowering the development processes in developing countries. The National Workshop feedback emphasized concerns with the bureaucracy of many international donors and suggested that a reduction in gatekeepers through greater use of technology could help.

Finally, Jamaica also wishes to make recommendations on the MDGs targets and indicators. These are intended to contribute to the discussions on the revision of the MDGs and to highlight actions to be taken in relation to policies and programmes. Some of these recommendations reflect earlier regional decisions within CARICOM and speak to goals and targets that are specific to Jamaica and other countries in the Caribbean region[41] (see annex for further detail).

It is suggested that universal access to early childhood education under MDG 2 be added as another target. Relating to that same goal, it is recommended that completion of secondary schooling also be considered as a target and that rates of illiteracy and functional literacy be added as indicators with special focus in 15-24 age group.

Violence is an impediment to the achievement of almost all other MDGs and therefore it is considered a discreet category, deserving of a target and related indicators that could monitor prevalence by age, sex and type of crime. Such a target would address the reduction of violence in all forms, including gender-based violence and gang violence. This target and recommended indicators could be added to Goal 3, gender equality and empowerment.

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[41] See *Caribbean Specific Targets & Indicators* (CARICOM Secretariat, September 2005). The Twelfth Meeting of the Council for Human and Social Development (COHSOD) (27-29 April, 2005) considered the MDGs in the current Caribbean socio-economic context and urged the identification of Caribbean specific indicators. In following up the COHSOD recommendations, the United Nations Development Fund for Women (UNIFEM), in collaboration with the CARICOM Secretariat, convened a meeting of its Task Force on Gender and Poverty in May 2005 to identify Caribbean specific gender indicators for the MDGs. The outcome of this taskforce was the document, *Caribbean Specific Targets & Indicators* which was submitted to CARICOM for presentation at the Millennium Development Summit in 2005.

As it relates to Goal 5, maternal mortality, reproductive health is undoubtedly tied to mortality yet not included as a distinct target. In this instance, it is recommended that a target be added to include the universal access to reproductive health. Related indicators could focus on monitoring the vulnerability of adolescents in this area. Chronic non-communicable diseases have been among the leading causes of death in Jamaica and in other parts of the developing world. Thus, this area could also have a target of its own, under Goal 6.

The impact of the global recession reminds us of how fragile humanity can be in the pursuit of economic prosperity. Therefore, the MDGs continue to provide United Nations member states with a vital integrated framework for looking at human and social development. In the context of the global recession, both its origin and consequences require concentrated focus on Goal No. 8, global partnerships, as the arrangements and commitments made in this area are now even more crucial for preventing slippage in the achievement of the goals. At the same time, distinctive socio-economic realities of member states, such as SIDs, indicate that the relevance of targets and indicators vary and in some cases, require specificity in approach. It is hoped that this forum with sharing of experiences on the MDGs will also provide countries with the opportunity for development cooperation and assistance towards global sustainable development that will effectively lift us out of the global recession.

Annex: Recommended new targets and indicators of the MDGs for Jamaica

Adapted from "Caribbean — specific targets and indicators", September 2005 CARICOM Secretariat All of the recommended amendments and new targets are in ***bold italics.***

GOALS & TARGETS	INDICATORS (new & amended)
Goal 1: Eradicate Poverty and Hunge.	
Amended Target: Halve, between 1990 and 2015, the proportion of people ***who fall below the poverty line***	○ Proportion of population ***living below the poverty line, by sex*** ○ Poverty gap ratio (incidence x depth of poverty), ***by sex*** ○ Share of poorest quintile in national consumption, ***by sex*** ○ Proportion of employed living in households with a household per capita income ***below the poverty line, by sex of head of household***
Goal 2: Achieve Universal Primary Education	
Amended Target: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary ***and secondary*** schooling.	○ Net enrolment ratio in primary education, ***by sex*** ○ Percentage of pupils starting secondary level ***form*** 1 who reach ***form*** 5, ***by sex*** ○ ***Illiteracy*** rate of 15-24 year olds, ***by sex*** ○ ***Functional literacy rate of 15-24 year olds, by sex*** ○ ***Pass rates in CXC subject areas (English and Mathematics), by sex***
New Target: ***Ensure that, by 2015 pre-school age children have universal access to early childhood education.***	○ ***Net enrolment ratio in early childhood institutions, by sex***
Goal 3: Promote Gender Equality and Empower Women	
New Target: ***Reduce, by one-third, all forms of violence, including gender-based violence and gang violence by 2015***	○ ***Number of violence related injuries by age, sex and type of weapon*** ○ ***Crime rate by type of crime by age and sex of offender and age and sex of victim*** ○ ***Percentage of cases of sexual violence completed through the court process in a 12-month period from the date of charge***
Goal 5: Improve Maternal Mortality	
Universal access to reproductive and sexual health services through the primary health-care system by 2015.	○ Adolescent (10-19) fertility rate ○ Proportion of pregnant adolescents (10-19) who attended antenatal care clinics. ○ Proportion of women ***and men*** aged 15-49, contracting sexually transmitted infections by type
Goal 6: Combat HIV/AIDS, Malaria and Other diseases	
New Target: ***Have halved by 2015 the incidence of chronic non-communicable diseases***	○ ***Prevalence of chronic non-communicable diseases by sex and age***

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